		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026518

Facility Name: Kewanee Care Home

Address: 144 Junior Ave. South (Number) Kewanee (City) 61443 (Zip Code)

County: Henry

Telephone Number: (309) 647-6400 **Fax #** (309) 853-4400

IDPA ID Number: 371068286001

Date of Initial License for Current Owners: 06/01/76

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 09/05/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	11	Skilled (SNF)	27	5,903	1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	57	22,781	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	84	28,684	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,314	3,314	8
9	SNF/PED					9
10	ICF	14,803	7,773		22,576	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,803	7,773	3,314	25,890	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.26%

D. How many bed-hold days during this year were paid by Public Aid?
41 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 3,314

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home
provider # **00026518**
12/31/2003

Schedule 2A

III Statistical Data - Page 2

	Beds at the Beg.		Num. of Days		Licensed Bed Days During Report Period
SNF	11	*	247	=	2,717
ICF	65	*	247	=	16,055
					18,772

	Beds at the End		Num. of Days		
SNF	27	*	118	=	3,186
ICF	57	*	118	=	6,726
					9,912

Total (agree to Schedule III, line 7, column 4) **$ 28,684**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	102,294	19,789		122,083		122,083	181	122,264			1
2	Food Purchase		108,029		108,029		108,029	(4,477)	103,552			2
3	Housekeeping	65,210	9,924		75,134		75,134		75,134			3
4	Laundry	62,016	12,903		74,919		74,919		74,919			4
5	Heat and Other Utilities			114,417	114,417		114,417	490	114,907			5
6	Maintenance	49,040	53,003	10,796	112,839		112,839	2,085	114,924			6
7	Other (specify):*											7
8	**TOTAL General Services**	278,560	203,648	125,213	607,421		607,421	(1,721)	605,700			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	964,583	98,570	1,100	1,064,253		1,064,253		1,064,253			10
10a	Therapy	65,048	778	1,000	66,826		66,826		66,826			10a
11	Activities	38,500	1,120		39,620		39,620		39,620			11
12	Social Services	22,456	38		22,494		22,494		22,494			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,090,587	100,506	10,100	1,201,193		1,201,193		1,201,193			16
	C. General Administration											
17	Administrative	103,930		85,582	189,512		189,512	(85,582)	103,930			17
18	Directors Fees											18
19	Professional Services			16,616	16,616		16,616	11,496	28,112			19
20	Dues, Fees, Subscriptions & Promotions			6,630	6,630		6,630	250	6,880			20
21	Clerical & General Office Expenses	40,911	5,496	19,713	66,120		66,120	(5)	66,115			21
22	Employee Benefits & Payroll Taxes			217,249	217,249		217,249	15,619	232,868			22
23	Inservice Training & Education			3,782	3,782		3,782	356	4,138			23
24	Travel and Seminar			1,126	1,126		1,126	1,211	2,337			24
25	Other Admin. Staff Transportation			6,272	6,272		6,272	1,288	7,560			25
26	Insurance-Prop.Liab.Malpractice			56,396	56,396		56,396	627	57,023			26
27	Other (specify):*											27
28	**TOTAL General Administration**	144,841	5,496	413,366	563,703		563,703	(54,740)	508,963			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,513,988	309,650	548,679	2,372,317		2,372,317	(56,461)	2,315,856			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Kewanee Care Home #0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			115,209	115,209		115,209	(20,664)	94,545			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,410	134,410		134,410	8,312	142,722			32
33	Real Estate Taxes			10,282	10,282		10,282		10,282			33
34	Rent-Facility & Grounds							2,335	2,335			34
35	Rent-Equipment & Vehicles			1,584	1,584		1,584	457	2,041			35
36	Other (specify):*											36
37	**TOTAL Ownership**			261,485	261,485		261,485	(9,560)	251,925			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,232		56,232		56,232		56,232			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,730	38,730		38,730		38,730			42
43	Other (specify):* Nonallowable Costs			47,014	47,014		47,014	(47,014)				43
44	**TOTAL Special Cost Centers**		56,232	85,744	141,976		141,976	(47,014)	94,962			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,513,988	365,882	895,908	2,775,778		2,775,778	(113,035)	2,662,743			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,359)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,027)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(24,698)	30		9
10	Interest and Other Investment Income	(20)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(644)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,823)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19)	43		24
25	Fund Raising, Advertising and Promotional	(22,974)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(27,831)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (88,395)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(24,640)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (24,640)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (113,035)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home

ID# 0026518

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset vending income	$ (740)	2	1
2	Offset miscellaneous income	(13,564)	21	2
3	Disallow Radiology	(13,527)	43	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,831)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Kewanee Care Home # 0026518 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	181	0	0	0	0	0	0	0	0	0	181	1
2	Food Purchase	(3,099)	0	0	0	0	0	0	0	0	0	0	(3,099)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	490	0	0	0	0	0	0	0	0	0	490	5
6	Maintenance	0	2,085	0	0	0	0	0	0	0	0	0	2,085	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,099)	2,756	0	0	0	0	0	0	0	0	0	(343)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(85,582)	0	0	0	0	0	0	0	0	0	(85,582)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,496	0	0	0	0	0	0	0	0	0	11,496	19
20	Fees, Subscriptions & Promotions	0	250	0	0	0	0	0	0	0	0	0	250	20
21	Clerical & General Office Expenses	(13,564)	13,559	0	0	0	0	0	0	0	0	0	(5)	21
22	Employee Benefits & Payroll Taxes	0	14,241	0	0	0	0	0	0	0	0	0	14,241	22
23	Inservice Training & Education	0	356	0	0	0	0	0	0	0	0	0	356	23
24	Travel and Seminar	0	1,211	0	0	0	0	0	0	0	0	0	1,211	24
25	Other Admin. Staff Transportation	0	1,288	0	0	0	0	0	0	0	0	0	1,288	25
26	Insurance-Prop.Liab.Malpractice	0	627	0	0	0	0	0	0	0	0	0	627	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,564)	(42,554)	0	0	0	0	0	0	0	0	0	(56,118)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,663)	(39,798)	0	0	0	0	0	0	0	0	0	(56,461)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Kewanee Care Home # 0026518 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(24,698)	4,034	0	0	0	0	0	0	0	0	0	(20,664)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20)	0	8,332	0	0	0	0	0	0	0	0	8,312	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,335	0	0	0	0	0	0	0	0	2,335	34
35	Rent-Equipment & Vehicles	0	0	457	0	0	0	0	0	0	0	0	457	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(24,718)	4,034	11,124	0	0	0	0	0	0	0	0	(9,560)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(47,014)	0	0	0	0	0	0	0	0	0	0	(47,014)	43
44	**TOTAL Special Cost Centers**	(47,014)	0	0	0	0	0	0	0	0	0	0	(47,014)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(88,395)	(35,764)	11,124	0	0	0	0	0	0	0	0	(113,035)	45

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	0.00%	$ 181	$ 181	1
2	V	5	Utilities		Petersen Health Care, Inc.	0.00%	490	490	2
3	V	6	Maintenance supplies		Petersen Health Care, Inc.	0.00%	2,085	2,085	3
4	V	17	Administrative	85,582	Petersen Health Care, Inc.	0.00%		(85,582)	4
5	V	19	Professional services		Petersen Health Care, Inc.	0.00%	11,496	11,496	5
6	V	20	Dues, fees & subscriptions		Petersen Health Care, Inc.	0.00%	250	250	6
7	V	21	Clerical & general office		Petersen Health Care, Inc.	0.00%	13,559	13,559	7
8	V	22	Employee benefits		Petersen Health Care, Inc.	0.00%	14,241	14,241	8
9	V	23	Inservice training & education		Petersen Health Care, Inc.	0.00%	356	356	9
10	V	24	Travel & seminar		Petersen Health Care, Inc.	0.00%	1,211	1,211	10
11	V	25	Other admin. staff transport		Petersen Health Care, Inc.	0.00%	1,288	1,288	11
12	V	26	Insurance-property & liab.		Petersen Health Care, Inc.	0.00%	627	627	12
13	V	30	Depreciation		Petersen Health Care, Inc.	0.00%	4,034	4,034	13
14	Total			$ 85,582			$ 49,818	$ * (35,764)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Petersen Health Care, Inc.	0.00%	$ 8,332	$ 8,332	15
16	V	34	Rent-facility & grounds		Petersen Health Care, Inc.	0.00%	2,335	2,335	16
17	V	35	Rent-equipment & vehicles		Petersen Health Care, Inc.	0.00%	457	457	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 11,124	$ * 11,124	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home
provider # 00026518
12/31/2003

Schedule 6A

VII Related Parties - Page 6

All owned 100% by Mark Petersen

Related Nursing Homes	City
In-State:	
Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Out-of-State:	
Meadow Lawn Nursing Center	Davenport, IA
Related Assisted Living	
Courtyard Estates	Kewanee, IL

Other Related Business Entities		
Petersen Health Care Companies	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100.00	323,538	1	2.50	Salary	$ 28,962	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 28,962		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Kewanee Care Center
Provider # 00026518
12/31/2003

Schedule 7A

VII Related Parties
C Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Countryview Terrace	Eastview Terrace	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	TOTAL
Mark Petersen	37,699	23,276	6,197	22,462	32,710	28,962	25,443	34,589	35,181	26,725	28,388	9,151	41,717	352,500

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient days	315,110	13	$ 2,200	$	25,890	$ 181	1
2	5	Utilities	Patient days	315,110	13	5,963		25,890	490	2
3	6	Maintenance supplies	Patient days	315,110	13	25,373		25,890	2,085	3
4	19	Professional services	Patient days	315,110	13	139,914		25,890	11,496	4
5	20	Dues, fees & subscriptions	Patient days	315,110	13	3,044		25,890	250	5
6	21	Clerical & general office	Patient days	315,110	13	165,031		25,890	13,559	6
7	22	Employee benefits	Patient days	315,110	13	173,328		25,890	14,241	7
8	23	Inservice training & education	Patient days	315,110	13	4,328		25,890	356	8
9	24	Travel & seminar	Patient days	315,110	13	14,743		25,890	1,211	9
10	25	Other admin. staff transport	Patient days	315,110	13	15,681		25,890	1,288	10
11	26	Insurance-property & liab.	Patient days	315,110	13	7,635		25,890	627	11
12	30	Depreciation	Patient days	315,110	13	49,093		25,890	4,034	12
13	32	Interest	Patient days	315,110	13	101,410		25,890	8,332	13
14	34	Rent-facility & grounds	Patient days	315,110	13	28,419		25,890	2,335	14
15	35	Rent-equipment & vehicles	Patient days	315,110	13	5,568		25,890	457	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 741,730	$		$ 60,942	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Bank		x	Van	$722.00	9/30/02	$ 43,315	$ 32,486	09/01/07	0.0400	$ 2,641	1
2	LaSalle Bank		x	Mortgage	$2,465+Int.	08/31/02	2,276,498	2,235,196	08/31/07	varies	124,539	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle		x	Line of credit	interest only	8/31/03	1,000,000	600,000	8/31/04	0.0450	7,210	6
7												7
8												8
9	TOTAL Facility Related				$722.00		$ 3,319,813	$ 2,867,682			$ 134,390	9
	B. Non-Facility Related*											
10									Home Office Allocation		8,332	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 8,332	14
15	TOTALS (line 9+line14)						$ 3,319,813	$ 2,867,682			$ 142,722	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 8,888	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 9,670	2
3. Under or (over) accrual (line 2 minus line 1).		$ 782	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 9,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 10,282	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	9,150	8
	1999	9,150	9
	2000	9,412	10
	2001	8,888	11
	2002	9,670	12

The 2002 Real Estate Tax Bill = $9,670

Estimated Accrual for 2002 = 9,500

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0026518

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-278-007	144 Junior Avenue	$ 46.22	$ 46.22
2.	25-05-281-017-0030	901 W. Mill Street	$ 91.60	$ 91.60
3.	25-04-151-009	144 Junior Avenue	$ 9,235.58	$ 9,235.58
4.	25-04-151-009	144 Junior Avenue	$ 0.02	$ 0.02
5.	25-04-151-008	144 Junior Avenue	$ 227.14	$ 227.14
6.	25-04-152-001	821 Dewey Avenue	$ 69.46	$ 69.46
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 9,670.02	$ 9,670.02

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,548 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	42,000	1976	$ 25,000	1
2	Facility	11,250	1992	25,621	2
3	TOTALS	53,250		$ 50,621	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		1976		$ 381,128	$ 147	30	$ 12,704	$ 12,557	$ 358,107	4
5	11		1998		753,696	19,325	40	18,842	(483)	105,201	5
6	8		2002		672,751	13,151	40	8,409	(4,742)	8,409	6
7											7
8											8
	Improvement Type**										
9	Various			1984	14,365	718	30	479	(239)	9,135	9
10	Various			1985	7,400	385	10		(385)	7,400	10
11	Various			1987	10,278	326	10-15	(83)	(409)	10,278	11
12	Various			1988	14,958	476	10-15	(152)	(628)	14,958	12
13	Various			1989	1,900	60	15	127	67	1,860	13
14	Various			1991	8,793	279	15	586	307	7,475	14
15	Various			1992	16,898	536	12	1,408	872	16,779	15
16	Various			1993	4,962	207	10	148	(59)	4,962	16
17	Various			1994	22,158	568	15	1,477	909	13,417	17
18	Various			1995	31,243	956	20	1,562	606	13,314	18
19	Tile Flooring			1996	1,083	28	20	54	26	423	19
20	Curtains Custom			1996	1,275	114	20	64	(50)	491	20
21	Emergency Light			1996	304	27	20	15	(12)	115	21
22	Fire Alarm			1996	2,099	187	20	105	(82)	805	22
23	Tile Flooring			1996	1,287	33	20	64	31	485	23
24	Boiler			1996	2,995	77	20	150	73	1,088	24
25	Water Heater Repair			1996	1,010		20	51	51	404	25
26	Ceiling Repairs			1996	2,117		20	106	106	839	26
27	Piping Repairs			1996	855		20	43	43	340	27
28	Fire Alarm			1996	1,331		20	67	67	480	28
29	Fire System			1996	1,564		20	78	78	579	29
30	Landscaping			1996	9,815		20	491	491	3,723	30
31	Landscaping			1996	1,986		20	99	99	726	31
32	Chrome Door Knob			1996	72		20	4	4	31	32
33	Emergency Light			1996	182		20	9	9	72	33
34	Painting			1996	672		20	34	34	266	34
35	Floor Tile			1997	8,472	217	20	424	207	2,897	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Storage Shed	1997	$ 10,177	$ 261	20	$ 509	$ 248	$ 3,266	37
38	Windows	1997	5,136	132	20	257	125	1,671	38
39	Ceiling Repairs	1997	8,291	213	20	415	202	2,628	39
40	Landscaping	1997	8,085	487	20	404	(83)	2,525	40
41	Landscaping	1997	1,298	78	20	65	(13)	406	41
42	Whirlpool	1997	9,343	240	20	467	227	2,841	42
43	Boiler	1997	3,000	77	20	150	73	925	43
44	Wing Additions	1997	3,700	95	20	185	90	1,125	44
45	Attic Piping	1997	3,318		20	166	166	1,065	45
46	Compressor	1997	809		20	40	40	243	46
47	Fire Alarm	1997	2,338		20	117	117	780	47
48	Code Alert Receiver	1997	1,863		20	93	93	620	48
49	New sign	1998	7,304	652	20	730	78	4,015	49
50	Landscaping	1998	21,500	1,324	20	1,075	(249)	6,092	50
51	Duct Work-New Wing	1999	1,494	38	20	75	37	337	51
52	Tiling	1999	914	23	20	46	23	207	52
53	Water Heater	1999	2,835	354	20	142	(212)	639	53
54	Water Heater	1999	3,766	471	20	188	(283)	846	54
55	Cubicle Partitions	1999	701	88	20	35	(53)	157	55
56	Beauty Salon	2000	943	24	20	47	23	165	56
57	Tile Flooring	2000	10,294	264	20	515	251	1,802	57
58	Lot/House Razed	2000	21,237	1,887	20	1,062	(825)	3,717	58
59	Concrete	2001	900	86	15	60	(26)	180	59
60	Landscaping	2001	1,045	69	15	70	1	211	60
61	Lighting	2001	3,438	88	39	88		264	61
62	Blinds/Curtains	2001	9,500	2,326	7	1,357	(969)	4,071	62
63	Landscaping	2002	24,614	237	15	1,641	1,404	2,461	63
64	Landscaping	2002	4,075	1,365	15	272	(1,093)	408	64
65	Architectural	2002	21,778	496	20	1,089	593	1,633	65
66	Carpeting	2002	2,551	14	20	128	114	192	66
67	Fire System	2002	4,677		20	234	234	351	67
68	Landscaping	2003	4,899	1,642	15	163	(1,479)	163	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,183,472	$ 50,848		$ 59,250	$ 8,402	$ 631,065	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 160,811	$ 55,587	$ 16,257	$ (39,330)	10	$ 62,105	71
72	Current Year Purchases	78,781	3,939	3,939		10	1,662	72
73	Fully Depreciated Assets	153,539					153,539	73
74	Allocated from Home Office			4,034	4,034			74
75	TOTALS	$ 393,131	$ 59,526	$ 24,230	$ (35,296)		$ 217,306	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1997 Dodge Caravan	1998	$ 32,369	$ 1,775	$ 4,047	$ 2,272	4	$ 32,369	76
77	Facility	2000 Town & Country	2002	35,088	3,060	7,018	3,958	5	10,527	77
78										78
79										79
80	TOTALS			$ 67,457	$ 4,835	$ 11,065	$ 6,230		$ 42,896	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,694,681	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 115,209	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 94,545	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (20,664)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 891,267	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6		Allocated from home office			2,335			6
7	TOTAL				$ 2,335 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,041 Description: Copier $1,584; Home office allocation $457
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18		N/A			18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C1	2780	hrs	$ 59,080		$	$	2,780	$ 59,080	1
2	Licensed Speech and Language Development Therapist	L10a, C1	186	hrs	5,578				186	5,578	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L10a. C1 & 2	15	hrs	390			778	15	1,168	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	L39, C2		# of prescrpts				56,232		56,232	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 65,048		$	$ 57,010	2,981	$ 122,058	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home
Provider #: 0026518
01/01/03 to 12/31/03

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,704,180	$ 5,704,180	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	404,346	404,346	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,367	9,367	6
7	Other Prepaid Expenses	9,224	9,224	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from related party	960,271	960,271	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,087,388	$ 7,087,388	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	151,595	50,621	13
14	Buildings, at Historical Cost	2,092,034	2,183,472	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	492,164	460,588	16
17	Accumulated Depreciation (book methods)	(1,007,633)	(891,267)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,728,160	$ 1,803,414	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,815,548	$ 8,890,802	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,409,096	$ 3,409,096	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,750	60,750	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,500	9,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	142,655	142,655	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,622,001	$ 3,622,001	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	32,486	32,486	39
40	Mortgage Payable	2,835,196	2,835,196	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,867,682	$ 2,867,682	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,489,683	$ 6,489,683	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,325,865	$ 2,401,119	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,815,548	$ 8,890,802	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Kewanee Care Home
Provider # 00026518
12/31/2003

Schedule 17A

XV. Balance Sheet - Unrestricted Operating Fund
C. Current Liabilities - Line 36

	Operating	After Consolidation
Due to Due From	6,948	6,948
Due to Patients	71,760	71,760
Accrued Vacation	46,057	46,057
Wage Garnishment	340	340
Accrued Expense	12,361	12,361
Accrued Sales Tax	181	181
Accrued Insurance	5,008	5,008
Total	142,655	142,655

See Accountants' Compilation Report

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,247,029	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(82,516)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,164,513	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	161,352	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 161,352	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,325,865	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,743,219	1
2	Discounts and Allowances for all Levels	(4,283)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,738,936	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	138,588	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 138,588	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,359	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	26,364	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	16,257	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,980	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	14,606	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,606	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,937,130	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	607,421	31
32	Health Care	1,201,193	32
33	General Administration	563,703	33
	B. Capital Expense		
34	Ownership	261,485	34
	C. Ancillary Expense		
35	Special Cost Centers	103,246	35
36	Provider Participation Fee	38,730	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,775,778	40
41	**Income before Income Taxes (line 30 minus line 40)****	161,352	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 161,352	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Kewanee Care Home
Provider # 00026518
12/31/2003

Schedule 19A

XVII. INCOME STATEMENT
Revenue - Line 28

E. Other Revenue (specify):	Amount
Transportation	302
Vending	740
Miscellaneous	13,564
	14,606

See Accountants' Compilation Report

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,924	1,924	$ 42,292	$ 21.98	1
2	Assistant Director of Nursing	1,993	1,993	31,310	15.71	2
3	Registered Nurses	1,769	1,818	34,769	19.12	3
4	Licensed Practical Nurses	18,159	18,868	277,638	14.71	4
5	Nurse Aides & Orderlies	54,858	56,815	531,145	9.35	5
6	Nurse Aide Trainees	1,820	1,820	42,987	23.62	6
7	Licensed Therapist	2,347	2,467	65,048	26.37	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,687	2,687	24,439	9.10	9
10	Activity Assistants	2,048	2,142	14,061	6.56	10
11	Social Service Workers	2,080	2,080	22,456	10.80	11
12	Dietician					12
13	Food Service Supervisor	2,244	2,244	21,948	9.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,882	12,087	80,346	6.65	15
16	Dishwashers					16
17	Maintenance Workers	4,529	4,529	49,040	10.83	17
18	Housekeepers	9,519	9,811	65,210	6.65	18
19	Laundry	8,541	8,833	62,016	7.02	19
20	Administrator	1,923	1,955	74,968	38.35	20
21	Assistant Administrator					21
22	Other Administrative	171	171	28,962	169.37	22
23	Office Manager	3,334	3,334	36,906	11.07	23
24	Clerical	100	100	4,005	40.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	433	433	4,442	10.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,361	136,111	$ 1,513,988 *	$ 11.12	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	8,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,100	L10, C3	39
40	Physical Therapy Consultant	19	1,000	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	19	$ 10,100		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jifi Jacob	Administrator	0	$ 74,968
Allocated from Home Office			
Mark Petersen	Administrative	100	28,962
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,930

B. Administrative - Other

Description	Amount
Management Fee (eliminated in column 7)	$ 85,582
TOTAL (agree to Schedule V, line 17, col. 3)	$ 85,582
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bush & Snyder Association	Legal	$ 1,962
Altschuler Melvoin & Glasser LLP	Accounting	3,180
American Express Tax & Business	Accounting	1,850
ADP	Computer Services	6,580
Ivans	Computer Services	606
Kewanee.com	Computer Services	344
LTC Solutions	Computer Services	1,320
Rudy Hadsell	Computer Services	774
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 16,616

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,049
Unemployment Compensation Insurance	17,213
FICA Taxes	113,465
Employee Health Insurance	44,719
Employee Meals	1,378
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,158
Employee Relations	9,062
401K Match	583
Allocated from Home Office	14,241
TOTAL (agree to Schedule V, line 22, col.8)	$ 232,868

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	973
Health Care Worker Background Check	
(Indicate # of checks performed 58)	706
Miscellaneous Licenses & Permits	3,678
Miscellaneous Dues	1,273
Allocated from Home Office	250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,880

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	812
Seminar Expense	314
Allocated from Home Office	1,211
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,337

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Kewanee Care Home
Provider #: 0026518
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	16,616
Allocated from Management Company	
Other	9,916
Legal	1,580
Total (agree to Schedule V, line 19, column 8)	28,112

See Accountants' Compilation Report

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6						N/A							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,691** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **38,730**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,378** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,359**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit currently in progress.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Kewanee Care Home** **12:16 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-113,035	equal to	-113,035	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	142,722	equal to	142,722	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	10,282	equal to	10,282	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	94,545	equal to	94,545	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,335	equal to	2,335	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,041	equal to	2,041	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	65,048	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	66,826	equal to	66,826	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	57,010	equal to	57,010	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	607,421	equal to	607,421	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,201,193	equal to	1,201,193	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	563,703	equal to	563,703	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	261,485	equal to	261,485	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	103,246	equal to	103,246	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	38,730	equal to	38,730	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	921,596	equal to	964,583	-42,987	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	42,987	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	65,048	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	38,500	equal to	38,500	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	22,456	equal to	22,456	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	102,294	equal to	102,294	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	49,040	equal to	49,040	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	65,210	equal to	65,210	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	62,016	equal to	62,016	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	103,930	equal to	103,930	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	40,911	equal to	40,911	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,513,988	equal to	1,513,988	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	8,000	< or = to	8,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,100	< or = to	1,100	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	103,930	equal to	103,930	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	85,582	equal to	85,582	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	16,616	equal to	16,616	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	232,868	equal to	232,868	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,880	equal to	6,880	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2,337	equal to	2,337	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	38,730	equal to	38,730	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	1,378	< or = to	15,619	-14,241	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	1,378	equal to	1,378	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,314	equal to	3,314	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-24,640	equal to	-24,640	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	2,867,682	equal to	2,867,682	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	9,500	equal to	9,500	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	50,621	equal to	50,621	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,183,472	equal to	2,183,472	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	460,588	equal to	460,588	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	891,267	equal to	891,267	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,325,865	equal to	2,325,865	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	161,352	equal to	161,352	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	8,815,548	equal to	8,815,548	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK**						
	TO THE COST REPORT!!		11/04/05		12:16:32 PM		
HSA Number	10	Name	Kewanee Care Home				
Cost report period	From:	01/01/03	To:	12/31/03	Base Number		336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N					
Licensed bed days:	28,684	Occupancy:	25,890	Pct. of occupancy:		90.26%	
Illinois Public Aid Support Rate			$				
Genl Services Salary/Wage:	278,560	Col 1, Line 8 ---Audit Adj:					
Genl Admin Salary/Wage	144,841	Col 1, Line 28 ---Audit Adj:					
Total Salary Wage	1,513,988	Col 1, Line 44 ---Audit Adj:					
Employee Benefits	232,868	Col 8, Line 22 ---Audit Adj:					
Total General Services:	605,700	Col 8, Line 8 ---Audit Adj:					
Total General Admin	508,963	Col 8, Line 28 ---Audit Adj:					

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amou out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amour by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$278,560
Divided by Total Wages (Column 1, Line 44	$1,513,988
General service wages as percent of total wages	18.3991%
Employee Benefits (Column 10, Line 22	$232,868
Allocation of Employee Benefits to General Services Costs	$42,846
Plus Total General Services (Column 10, Line 8	$605,700
New Total General Services Cost	$648,546

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by the proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from you General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$144,841
Divided by Total Wages (Column 1, Line 45	$1,513,988
General administration wages as a percent of total wages	9.5669%
Employee Benefits (Column 10, Line 22	$232,868
Allocation of Emplayee Benefits to General Admin. Cost	$22,278
Plus Total General Administration (Column 10, Line 2	$508,963
Minus Total Fringe (Column 10, Line 2:	$232,868
New Total General Administration Cos	$298,373

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$648,546	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$648,546

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$298,373	
General Administration Multiplier (Step II-B	1	
Updated General Services Cost		$298,373
3 Total Updated Support Costs (1 + 2		$946,919

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO	$36.21

A. If the occupancy (Cost Report, Page 2, Schedule III-C) i equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patien days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$946,919
Total Patient Days (Cost Report	25,890
Support Costs per Diem	$36.57

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	28,684
Multiplied by	0.93
	26,676
Minus total Patient Day	25,890
	786
One-third of difference	262
Plus Total Patient Day	25,890
Adjusted Occupancy	26,152
Total Support Costs (Step II, C, 3, above	$946,919
Divided by Adjusted Occupany	26152
Support Costs Per Diem	$36.21

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$40.08
Minus Support Costs Per Dier	$36.21
Difference	$3.87
Multiply the Difference by	0.5
One-Half of the Difference	$1.94
Plus Support Costs Per Dier	$36.21
Support Rate if costs are between 35th and 75th percentile	38.15

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$40.08
Minus Support Costs Per Dier	$36.21
Difference	$3.87
Multiply the Difference by	0.5
One-Half of the Difference	$1.94
Compare one-half the difference to the profit ceiling for your HSA in Table II and	4.04
Enter the Lower of the Two Amounts	$1.940
Plus Support Costs Per Dier	$36.21
Support Rate if support costs less than 35th percentile	$38.15

D. **YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abo** **$38.15**

75th Percentile is	$40.08
35th Percentile is	$32.10

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/04/05 12:16:32 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Kewanee Care Home** ID: **0026518**

HSA No.: 10 Own or Rent? (O or R) O Own or Rent Beginning: 6/1/1976

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	84	Total Patient Days	25,890
Begin	**01/01/03**	Licensed Bed Days:	28,684	% Occupied	90.26%
End	**12/31/03**			Capital Days	26,676

1989 Property Tax COST: ______ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ______ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ______ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1996
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	375897
2. Total licensed beds from cost report Page 2, Line 7, column 3	84
3. Line 1 divided by Line 2	$4,475
4. Regional construction inflator from Table 2	1.12
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	5012
C. Obtain the Uniform Building Value from Table 1	33141
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	5012
2. Uniform building value from Line C	33141
3. Add Lines 1 and 2	38153
4. Divide by 2 to obtain average	19077
5. Enter 120% of line C	39769
6. The blended value is the lesser of Line 4 or Line 5	19077
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	56.2743
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	6.19
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	8.69
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	26,676
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	1.0815
5. Equals: Updated Property Tax Cost	0

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	25,890
2. Total Licensed Bed Days * .93	26676
3. Capital Days (higher of Line 1 or Line 2)	26,676

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	8.69
2. Add Property Tax from Line J5	0
3. Total capital rate (add Lines 1 & 2)	8.69

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	0	0	0	12
2	2	0	0	0	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	84	14365	1206660	12
7	7	85	7400	629000	12
8	8	87	10278	894186	12
9	9	88	14958	1316304	12
10	10	89	1900	169100	12
11	11	91	8793	800163	12
12	12	92	16898	1554616	12
13	13	93	4962	461466	12
14	14	94	22158	2082852	12
15	15	95	31243	2968085	12
16	16	96	1083	103968	12
17	17	96	1275	122400	12
18	18	96	304	29184	12
19	19	96	2099	201504	12
20	20	96	1287	123552	12
21	21	96	2995	287520	12
22	22	96	1010	96960	12
23	23	96	2117	203232	12
24	24	96	855	82080	12
25	25	96	1331	127776	12
26	26	96	1564	150144	12
27	27	96	9815	942240	12
28	28	96	1986	190656	12
29	29	96	72	6912	12
30	30	96	182	17472	12
31	31	96	672	64512	12
32	32	97	8472	821784	12
33	33	0	0	0	12
34	34	97	10177	987169	12A
35	35	97	5136	498192	12A
36	36	97	8291	804227	12A
37	37	97	8085	784245	12A
38	38	97	1298	125906	12A
39	39	97	9343	906271	12A
40	40	97	3000	291000	12A
41	41	97	3700	358900	12A
42	42	97	3318	321846	12A
43	43	97	809	78473	12A
44	44	97	2338	226786	12A
45	45	97	1863	180711	12A
46	46	98	7304	715792	12A
47	47	98	21500	2107000	12A
48	48	99	1494	147906	12A
49	49	99	914	90486	12A
50	50	99	2835	280665	12A
51	51	99	3766	372834	12A
52	52	99	701	69399	12A
53	53	100	943	94300	12A
54	54	100	10294	1029400	12A
55	55	100	21237	2123700	12A
56	56	101	900	90900	12A
57	57	101	1045	105545	12A
58	58	101	3438	347238	12A
59	59	101	9500	959500	12A
60	60	102	24614	2510628	12A
61	61	102	4075	415650	12A
62	62	102	21778	2221356	12A
63	63	102	2551	260202	12A
64	64	102	4677	477054	12A
65	65	103	4899	504597	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
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85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
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105	0	0	0	12C
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156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

36142206 375897 96.14922705

Base Year = 1996

TABLE 1 2

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 1

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	102,294	19,789	0	122,083	0	122,083	181	122,264
2. Food Purchase	0	108,029	0	108,029	0	108,029	-4,477	103,552
3. Housekeeping	65,210	9,924	0	75,134	0	75,134	0	75,134
4. Laundry	62,016	12,903	0	74,919	0	74,919	0	74,919
5. Heat and Other Utilities	0	0	114,417	114,417	0	114,417	490	114,907
6. Maintenance	49,040	53,003	10,796	112,839	0	112,839	2,085	114,924
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	278,560	203,648	125,213	607,421	0	607,421	-1,721	605,700
9. Medical Director	0	0	8,000	8,000	0	8,000	0	8,000
10. Nursing & Medical Records	964,583	98,570	1,100	1,064,253	0	1,064,253	0	1,064,253
10a. Therapy	65,048	778	1,000	66,826	0	66,826	0	66,826
11. Activities	38,500	1,120	0	39,620	0	39,620	0	39,620
12. Social Services	22,456	38	0	22,494	0	22,494	0	22,494
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,090,587	100,506	10,100	1,201,193	0	1,201,193	0	1,201,193
17. Administrative	103,930	0	85,582	189,512	0	189,512	-85,582	103,930
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	16,616	16,616	0	16,616	11,496	28,112
20. Fees, Subscriptions & Promotion	0	0	6,630	6,630	0	6,630	250	6,880
21. Clerical & General Office	40,911	5,496	19,713	66,120	0	66,120	-5	66,115
22. Employee Benefits & Payroll	0	0	217,249	217,249	0	217,249	15,619	232,868
23. Inservice Training & Education	0	0	3,782	3,782	0	3,782	356	4,138
24. Travel and Seminar	0	0	1,126	1,126	0	1,126	1,211	2,337
25. Other Admin. Staff Trans	0	0	6,272	6,272	0	6,272	1,288	7,560
26. Insurance-Prop.Liab.Malpractice	0	0	56,396	56,396	0	56,396	627	57,023
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	144,841	5,496	413,366	563,703	0	563,703	-54,740	508,963
29. Total General Administrative	1,513,988	309,650	548,679	2,372,317	0	2,372,317	-56,461	2,315,856
30. Depreciation	0	0	115,209	115,209	0	115,209	-20,664	94,545
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	134,410	134,410	0	134,410	8,312	142,722
33. Real Estate	0	0	10,282	10,282	0	10,282	0	10,282
34. Rent - Facility & Grounds	0	0	0	0	0	0	2,335	2,335
35. Rent - Equipment & Vehicles	0	0	1,584	1,584	0	1,584	457	2,041
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	261,485	261,485	0	261,485	-9,560	251,925
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	56,232	0	56,232	0	56,232	0	56,232
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	38,730	38,730	0	38,730	0	38,730
43. Other (specify):*	0	0	47,014	47,014	0	47,014	-47,014	0
44. Total Special Cost Ce	0	56,232	85,744	141,976	0	141,976	-47,014	94,962
45. Grand Total	1,513,988	365,882	895,908	2,775,778	0	2,775,778	-113,035	2,662,743

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	5,704,180	5,704,180
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	404,346	404,346
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	9,367	9,367
7. Other Prepaid Expenses	9,224	9,224
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	960,271	960,271
10. Total current assets	7,087,388	7,087,388
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	151,595	50,621
14. Buildings, at Historical Cost	2,092,034	2,183,472
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	492,164	460,588
17. Accumulated Depreciation (book methods)	-1,007,633	-891,267
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,728,160	1,803,414
25. Total Assets	8,815,548	8,890,802
CURRENT LIABILITIES		
26. Accounts Payable	3,409,096	3,409,096
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	60,750	60,750
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	9,500	9,500
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	139,676	139,676
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	3,619,022	3,619,022
LONG TERM LIABILITES		
39.Long-Term Notes Payable	32,486	32,486
40.Mortgage Payable	2,835,196	2,835,196
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	2,867,682	2,867,682
46.Total Liabilities	6,486,704	6,486,704
47.Total Equity	2,328,844	2,404,098
48.Total Liabilities and Equity	8,815,548	8,890,802

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,743,219
2. Discounts and Allowances for all Levels	-4,283
Subtotal - Inpatient Care	2,738,936
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	138,588
7. Oxygen	0
Subtotal - Anciliary Revenue	138,588
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,359
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	26,364
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	16,257
22. Laundry	0
Subtotal - Other Operating Revenue	44,980
24. Contributions	0
25. Interest and Other Investments Income	20
Subtotal - Non-Operating Revenue	20
27. Other Revenue (specify):	14,606
28. Other Revenue (specify):	0
Subtotal - Other Revenue	14,606
30. Total Revenue	2,937,130
31. General Services	607,421
32. Health Care	1,201,193
33. General Administration	563,703
34. Ownership	261,485
35. Special Cost Centers	103,246
35. Provider Participation Fee	38,730
37. Other	0
40. Total Expenses	2,775,778
41. Income Before Income Taxes	161,352
42. Income Taxes	0
43. Net Income or Loss for the Year	161,352

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23	Provider Participation fee is linked from page 4